Pending CMS approval

Blue Cross® Preferred Bronze

An individual HMO health plan from Blue Care Network of Michigan

You will have a broad choice of doctors and hospitals from Blue Care Network's entire network, the largest HMO network in Michigan. Your primary care doctor will coordinate your care and refer you to specialists when necessary. Other than emergency services and accidental injuries, care outside the network is not covered. Use our *Find a Doctor* tool at **bcbsm.com/find-a-doctor** to see if your doctor is in the Preferred HMO network.

Benefits	In-network
Annual deductible	**Individual plan (one member)**
	$5,950 per individual plan per calendar year. Medical and drug expenses are combined to meet the integrated deductible.
	Family plan (two or more members)
	$11,900 per family plan per calendar year. Medical and drug expenses are combined to meet the integrated deductible.
	NOTE: If the contract is a family contract, and one member on the contract meets the individual deductible, BCN will begin paying covered benefits for that member only. The remainder of the family deductible must be met by one or more family members before BCN will begin paying covered benefits for the rest of the members on the family contract.
Coinsurance	40% after deductible for most services 50% after deductible for bariatric, temporomandibular joint, infertility, prosthetics and orthotics and durable medical equipment services
Out-of-pocket maximum The integrated deductible, coinsurance and copays for all medical and drug expenses accumulate to the out-of-pocket maximum.	**Individual plan (one member)**
	$6,350 per member
	Family plan (two or more members)
	$12,700 per family
	NOTE: If the contract is a family contract, and one member on the contract meets the individual out- of- pocket maximum, BCN will begin paying 100% of the approved amount for covered benefits for that member only. The remainder of the family out-of-pocket maximum must be met by one or more family members before BCN will begin paying 100% of the approved amount for covered benefits for the rest of the members on the family contract.
Preventive care	
Preventive medical, prescription drugs and immunizations include: health maintenance exam, select laboratory services, gynecologic exam, pap smear screening, mammogram screening, select female contraceptives, female voluntary sterilization and other adult and childhood preventive services and immunizations in compliance with the provisions of the Patient Protection and Affordable Care Act.	Covered 100% with no deductible, copay or coinsurance

Find other important information about Blues benefits and membership at **bcbsm.com/importantinfo**.

Call a health plan advisor at 1-877-469-2583 if you have any questions.

Benefits	In-network
Preventive care *continued*	
Screening colonoscopy	Covered 100% with no deductible, copay or coinsurance. Routine colonoscopy must be billed as preventive to be covered at 100%.
Pediatric services	
Well baby and child	Covered 100% with no deductible, copay or coinsurance
Pediatric dental	Stand alone plan available for purchase
Pediatric vision	Covered 100%, one vision exam per pediatric member per calendar year Covered 100%, standard lenses and frames or contact lenses Frequency limits apply
Ambulatory services	
Physician office visits, presurgical consultations and office consultations, and online visits	$30 copay per primary care office visit or online visit and $50 copay per specialist office visit after deductible. Diagnostic and laboratory services are subject to plan's deductible and coinsurance.
Urgent care — physician's office	$30 copay per primary care visit and $50 copay per specialist office visit after deductible. Diagnostic and laboratory services are subject to plan's deductible and coinsurance.
Laboratory and diagnostic services	
Laboratory tests and pathology	Covered 60% after deductible
Diagnostic tests and X-rays (including electrocardiogram, chest X-ray)	Covered 60% after deductible
Imaging services: CT scans, MRIs, PET, etc. Prior authorization required	$200 copay after deductible, then covered 60%
Allergy testing and therapy in a physician's office	Covered 60% after deductible
Maternity and newborn care	
Maternity benefit	$500 copay after deductible, then covered 60%
Prenatal visits	Covered 100% with no deductible, copay or coinsurance. Diagnostic and laboratory services are subject to plan's deductible and coinsurance.
Postnatal visits	$30 copay per visit after deductible. Diagnostic and laboratory services are subject to plan's deductible and coinsurance.
Emergency services	
Emergency room	$250 copay after deductible, then covered 60%. Copay waived if admitted.
Ambulance services	Covered 60% after deductible
Urgent care visits Urgent care center or outpatient location	$40 copay after deductible. Diagnostic and laboratory services are subject to plan's deductible and coinsurance.

Benefits	In-network
Hospitalization and other services	
Inpatient hospital care, long-term acute care hospital (semiprivate room); skilled nursing facility — Limited to a maximum of 45 days per member per calendar year	$500 copay after deductible, then covered 60%
Physician surgical services	Covered 60% after deductible
Home health care	Covered 60% after deductible
Chemotherapy	Covered 60% after deductible
Organ transplant and specified organ transplant BCN-designated facilities only	Covered 60% after deductible
Sleep studies including testing and surgeries	Covered 60% after deductible
Bariatric surgery — once per lifetime	Covered 50% after deductible
Male voluntary sterilization	Covered 60% after deductible
Rehabilitative and habilitative services and devices	
Outpatient physical and occupational therapy	Covered 60% after deductible Limited to a combined maximum of 30 visits per member per calendar year
Chiropractic spinal manipulation and osteopathic manipulative therapy	Covered 60% after deductible Limited to a combined maximum of 30 visits per member per calendar year
Speech therapy	Covered 60% after deductible Limited to a maximum of 30 visits per member per calendar year
Cardiac and pulmonary rehabilitation	Covered 60% after deductible Limited to a combined maximum of 30 visits per member per calendar year
Specified autism spectrum disorder — applied behavioral analysis	Covered 60% after deductible. Services must be preauthorized by BCN.
Durable medical equipment and prosthetic and orthotic appliances BCN-approved suppliers only	Covered 50% after deductible
Diabetes supplies and outpatient diabetes self-management training	Covered 60% after deductible
Mental health and substance abuse	
Inpatient and residential mental health	$500 copay after deductible, then covered 60%
Outpatient mental health	Covered 60% after deductible
Inpatient and residential substance abuse	$500 copay after deductible, then covered 60%
Outpatient substance abuse	Covered 60% after deductible

Benefits	In-network
Prescription drugs	
Prescription drugs 1 to 30 days (retail network pharmacy and mail-order provider)	**Tier 1a — Preferred generic:** $4 copay after integrated deductible **Tier 1b — Nonpreferred generic:** $20 copay after integrated deductible **Tier 2 — Preferred brand:** 25% coinsurance after integrated deductible, $40 minimum and $100 maximum copay **Tier 3 — Nonpreferred brand:** 50% coinsurance after integrated deductible, $80 minimum and $100 maximum copay **Tier 4 — Preferred specialty:** 20% coinsurance after integrated deductible, no minimum and $200 maximum copay (30 day supply only) **Tier 5 — Nonpreferred specialty:** 25% coinsurance after integrated deductible, no minimum and $300 maximum copay (30 day supply only)
Prescription drugs 31 to 90 days Note: Specialty drugs (Tier 4 and 5) are limited to a 30-day supply. (90-day retail network pharmacy or mail-order provider)	**Tier 1a — Preferred generic:** $12 copay after integrated deductible **Tier 1b — Nonpreferred generic:** $60 copay after integrated deductible **Tier 2 — Preferred brand:** 25% coinsurance after integrated deductible, $120 minimum and $300 maximum copay **Tier 3 — Nonpreferred brand:** 50% coinsurance after integrated deductible, $240 minimum and $300 maximum copay **Tier 4 — Preferred specialty:** Not covered **Tier 5 — Nonpreferred specialty:** Not covered

Note

To be eligible for coverage, the following services require approval before they are provided: inpatient acute care, rehabilitation services, some radiology services (CT, CTA, MRI, MRA, MRS, QCT bone densitometry, nuclear cardiology, PET and PET/CT fusion, diagnostic CT colonography, CT abdomen and pelvis), sleep studies, mental health and substance abuse, skilled nursing facilities, self- and physician-administered specialty drugs, applied behavioral analysis and human organ transplant services.

Pricing information for various procedures by in-network providers can be obtained by calling the Customer Service number listed on the back of your BCN ID card and providing the procedure code. Your provider can also provide this information upon request.

Exclusions and limitations: Conditions covered by workers' compensation or similar law; services or supplies not specifically listed as covered under your benefit plan; services received before your effective date or after coverage ends; services you wouldn't have to pay for if you did not have this coverage; services or supplies that are not medically necessary; physical exams for insurance, employment, sports or school; any amounts in excess of BCN's approved amount; cosmetic surgery, admissions and hospitalizations; services for gender reassignment or for the treatment of gender identity disorder including hormonal therapy; dental care, dental implants or treatment to the teeth except as specifically stated in your benefit plan; hearing aids; infertility-related drugs; private duty nursing; telephone, fax machine or any other type of electronic consultation; educational services, except as specifically provided or arranged by BCN or specifically stated in your benefit plan; care or treatment furnished in a nonparticipating hospital, except as specifically stated in your benefit plan; personal comfort items; custodial care; services or supplies supplied to any person not covered under your benefit plan; services while confined in a hospital or other facility owned or operated by state or federal government, unless required by law; voluntary abortions or vasectomy reversals; RK, PRK or Lasik; services provided by a professional provider to a family member; services provided by any person who ordinarily resides in the covered person's home or who is a family member; any drug, medicine or device that is not approved by the Food and Drug Administration, unless required by law; vitamins, dietary products and any other nonprescription supplements except as specifically stated in your benefit plan; dental services, except for dental injury; appliances, supplies or services as a result of war or any act of war, whether declared or not; communication or travel time, lodging or transportation, except as stated in your benefit plan; foot care services, except as stated in your benefit plan; health clubs or health spas, aerobic and strength conditioning, work-hardening programs and related material and products for these programs; hair prosthesis, hair transplants or implants; experimental treatments, except as stated in your benefit plan; and alternative medicines or therapies.

This document is intended to be an easy–to–read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. A complete description of benefits is contained in the applicable Blue Care Network certificate and riders. In the event of a conflict between this document and the applicable certificate and riders, the certificate and riders will rule. Payment amounts are based on the BCN–approved amount, less any applicable deductible, copay and/or coinsurance amounts required by the plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan.

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association